Medicaid Management Information Systems

Provider Participation, Cost Containment Initiatives: State Characteristics

Summer, 1991

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Introduction

This report was prepared by the American Public Welfare Association (APWA) under contract with the Health Care Financing Administration (contract # 90-038-PK). The purpose of the effort was to ascertain what Medicaid Management Information Systems (MMIS) changes states had undertaken in recent years that were implemented to either improve provider participation/provider relations or to contain costs, or both.

APWA designed the survey by working with state Medicaid staff and HCFA. Questions were designed to focus on whether states have adopted certain systems improvements to facilitate provider participation and/or contain costs. Specifically, the survey asked states about on-line eligibility verification, on-line claims adjudication, claims editing and drug utilization review. The survey also attempted to gather general background information that will assist the reader in interpreting survey responses. APWA took the opportunity presented by the survey to query states about the systems modifications required by some recent federal mandates. A trial survey was sent out to a sample of states for review and comment prior to sending a final survey to all states. Surveys were mailed to all states in March, 1991 and were received back in the following two months. A copy of the survey is contained in Appendix A.

Background Information

Forty-four Medicaid agencies* responded to the survey. The average reported age of the MMIS across states is ten years. The oldest system as reported on the surveys is twenty years old, belonging to Virginia. The newest system belongs to Arizona, which was operational for only one month as of April, 1991.

Thirteen states reported they currently had no fiscal agent, while Pennsylvania and South Carolina reported using a fiscal agent for front-end claims processing only. Texas reported using a fiscal agent to process certain claims while the state processes primarily nursing home and pharmacy claims in-house. EDS was the most frequently reported current fiscal agent (13 states).

Twenty-two of the reporting states indicated the presence of an eligibility subsystem (as distinct from the reference file subsystem). Thirty-four states reported a Third Party Liability (TPL) subsystem of the MMIS. Neither of these subsystems are required of an MMIS. One other state reported a TPL data system that was not an MMIS subsystem.

Interestingly, Alaska and Indiana reported the existence of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) subsystem while Arkansas and Montana indicated they are considering developing an EPSDT subsystem. It must be noted that the survey did **not** query states on the existence of EPSDT MMIS subsystems so survey responses on EPSDT subsystems cannot be considered conclusive. This issue may warrant further exploration as states work on the systems aspect of new EPSDT requirements (notably tracking child health screens and reporting EPSDT client participation).

The following chart summarizes the background data reported on the survey.

*(DC, MA, MO, NH, NJ, RI and WV did not respond)

TABLE 1 - MMIS BACKGROUND DATA AS OF APRIL, 1991

State	MMIS Age	Eligibility Subsystem	TPL Subsystem	EPSDT Subsystem	Current Fiscal Agent
AL	12 yrs	✓	✓		EDS
AK	2.5 yrs	✓	✓	✓	TVCC
AZ	1 mo	✓	✓		state
AR	6 yrs	✓	✓	?	EDS
CA	13 yrs	✓	✓		EDS
CO	12 yrs		✓		BC/BS
CT	9.5 yrs				EDS
DE	6 mos		✓		EDS
DC	NR				
FL	12 yrs	✓	✓		Consultec
GA	4 yrs		✓		EDS
HI	18 yrs		✓		HI Medical Services Assn
ID	14 yrs	✓	✓		EDS
IL	10 yrs				state
IN	14 yrs		✓	✓	Associated Group Contractors
IA	11 yrs				Unisys
KS	13 yrs		✓		EDS
KY	10 yrs		✓		EDS
LA	12 yrs	✓	✓		Unisys
ME	13 yrs				state
MD	6 yrs	✓	✓		state
MA	NR				
MI	6 yrs	✓	✓		state
MN	18 yrs	✓	✓		state
MS	12 yrs	✓			state
MO	NR				
MT	5 yrs	✓	✓(not a subsystem)	?	Consultec
NE	14 yrs	✓	✓		state
NV	Not an MMIS State				
NH	NR				
NJ	NR				
NM	1 yr		✓		TCC
NY	14 yrs	✓	✓		CSC
NC	10 yrs		✓		EDS
ND	12.5 yrs	✓	✓		state
OH	5 yrs				state
OK	5 yrs		✓		Unisys
OR	9 yrs	✓	✓		state
PA	13 yrs		✓		TCC(front end processing), and state
RI	NR				
SC	12 yrs		✓		BC/BS (front end processing)
SD	10 yrs				state
TN	6 yrs	✓	✓		TCC
TX	15 yrs	✓	✓		Nat'l Heritage Ins. Co. for processing some claims, state processes some claims
UT	7 yrs	✓	✓		state
VT	10 yrs		✓		EDS
VA	20 yrs	✓			TCC
WA	9 yrs		✓		Consultec
WVA	NR				
WI	13 yrs	✓	✓		EDS
WY	2 yrs		✓		EDS

✓ = yes, an MMIS subsystem

blank = no, not an MMIS subsystem

? = under consideration

NR = no response

On-Line, Real-Time Eligibility Verification

A total of 24 states have an eligibility verification system available to providers that is either under development or already implemented. Another five states (CT, ID, KY, TN, TX) indicated a system is only under consideration as of the Spring, 1991.

Although the survey requested information about on-line, real-time eligibility verification systems, survey responses varied considerably. There is a problem in consistent definition and use of the term "real-time." Some states indicated they had such a system but, in fact, did not employ date-specific eligibility and their files were updated either weekly or bi-weekly. Other states using an on-line eligibility system that was updated once every 24 hours answered "no" to the same question.

In order to avoid the methodological problem posed by the lack of consistent definition, APWA called states that answered "no" but indicated they had an on-line system, and integrated all responses into the survey summary without making a clear distinction on when a state updated its eligibility files other than self-reported use of date-specific eligibility.

Of the 24 states that reported in the affirmative to an on-line, real-time eligibility system, 14 have already implemented such a system while 12 intend to implement such a system. Michigan and Illinois have a system currently in place but intend to implement another system in the near future.

Maryland appears to have the oldest telephone voice response system (since 1984) while Michigan has the oldest provider PC based system (1985). The survey requested information on which provider types could access the system and the estimated percentage utilization of the system within each provider type. Information on percentage utilization was generally not reported by states so APWA did not report on this part of the survey.

States Utilizing On-Line Eligibility Verification

New York and Florida were the only reporting states that indicated use of point of sale (POS) devices. New York uses both POS and card swipe while Maryland reported provider discretion in using card swipe but indicated it does not utilize POS.

Six states (FL, IL, KS, MI, MT, UT) have provider PC based eligibility verification systems. In New York, a PC based system is under development. Fees for these systems are handled in a variety of ways—per inquiry, monthly fee, annual fee, one-time start-up fee, or any combination of these charges. Michigan and Utah reported that providers bore no cost for the PC based system. Only one state, Florida, reported implementing both a telephone voice response and a provider PC access system.

In general, the states with PC based eligibility verification systems reported fairly broad availability among various provider types although anecdotally it appears that it is high volume providers who use the system—this is probably due to the costs incurred by providers of the system. No state indicated that it bore the costs of hardware and only one state, Michigan, reported that it paid the telecommunications costs for the PC access system, while only Kansas reported supplying the software. New York, which is developing a provider PC based system, is the only state reporting a link with on-line claims adjudication which is also under development.

The scope of client information made available to the provider through the PC based system varied quite a bit. Florida, Illinois, Montana, and Utah employ date specific eligibility terminations—the client coverage is terminated when the information becomes available rather than at the first of the following month. Florida, however, uses date specific eligibility for only certain groups of eligibles and the Illinois system provides information on all recent periods of eligibility. In addition to other client information, Michigan provides information on managed care restrictions and primary care case management. All but one PC access state included third party payor information.

Nine states (CA, FL, IA, MD, NE, NY, OH, OR, WI) reported using a voice response eligibility system. In general, the system seems widely available to many provider types. In Maryland and Oregon, use of the system is encouraged by a guaranteed payment if the provider documents that the eligibility verification system was accessed prior to rendering service.

Florida, Nebraska and New York use date specific eligibility in their voice response systems. Iowa provides information on managed care (plan restrictions) and relevant information related to primary care case management. New York, in addition to other client information, indicates any service authorization information. Oregon includes information on the date of the last EPSDT screen in its voice response system. Wisconsin includes information on the authorized level of nursing care and the dollar amount of the providers' next payment. All but one voice response state included third party payor information in the voice response system.

Four states, all with voice response systems, provide training to users of the system, and two states (Oregon and New York) funded telecommunication costs. Six of the states either did not respond to this question or found the question to not be applicable.

Twelve states indicated that at least one of the reasons for implementing an eligibility verification system was to improve provider participation/relations. While the majority of states indicated participation/relations had improved as a result, only two states (California, Montana) indicated they could document the improvement. Six states indicated the eligibility system was implemented to provide cost-savings, and three of these states indicated that savings could be estimated or documented.

Four states among the 14 reporting on an implemented system indicated that the system was funded through enhanced federal matching payments (CA, MD, NY, OR). It is interesting to note that these four states have a voice response system; no state with a provider PC based system reported enhanced match. The survey proved to be an insufficient tool by which to ascertain why some voice response systems were eligible for enhanced match while others were not.

The following table summarizes characteristics of eligibility verification systems already developed.

TABLE 2 - IMPLEMENTED ON-LINE ELIGIBILITY VERIFICATION SYSTEM (QUESTION 6)

State	Date	Avail. To Whom	POS	Card Swipe	Tel. Voice Response	Pro-vider PC Base	On-Line Claims Adj.	Date Specific Eligib.	Client Info.	Provider Costs	XIX Asst.	Other Incen-tives	Purpose✚	Proof▲	Enhanced FFP	EBT
CA	'89	a,b,d-g			✓				1-5	50 cents per inquiry	training		part.	✓	✓	NR
FL☆	'89	a-e	✓		✓	✓		✓*	1-6	variable			part.		NA	
IL	NR	e, clinics				✓		✓**		mo. charge, trans. fee, line charge	NR	NR	NR	NR	NR	NR
IA	'90	a-g			✓				5, HMO info, case mgt.		training	NR	part.	NR		
KS	NR	a-g				✓			2, 4, 5	annual fee, variable monthly, line charge	software	NR	part.	NR		
MD	'84	a-e		✓***	✓				1-3, 5-6		NA	guar. payment	$ part.	✓	✓	
MI	'85	a-e, ambu-lance				✓			1-3, 5, HMO Info, case mgt.		telecomm. costs		part.			
MT	'87	a-g				✓		✓	1-5, 7	$150 start-up fee	NA		part.	✓		
NE	'89	a-g			✓			✓	1-5		NR		reduce elig. problems	NR		
NY	'86	a-g	✓	✓	✓	✓****	✓****	✓	1-3, 5, service auth.		hardware, training, telecomm. costs		$ part.	✓	✓	
OH	'91	a-e			✓						NR		$ part.			
OR	'86	a-c, e			✓				3, 5, EPSDT screen date		training, telecomm. costs	guar. payment	$ part.	✓	✓	
UT	'89	a, b, e				✓		✓	1-5		training		$ part.			
WI	NR	a-g			✓				NF level of care, 5, amt. of next payment	telecomm. costs	NR		$ part.	NR	NR	NR

✚ *Purpose of implementing the system: provider participation (part.), cost savings ($), or other.*

▲ *While most states could not document improved provider participation or cost savings, most respondents felt money was saved and/or provider relations had improved.*

☆ *Florida reported use of voice response, Envoy, Medifax, and Mediclaim.*

✓ = *Yes*

blank = No

a = pharmacists
b = individual medical providers
c = group health providers
d = nursing facilities
e = hospitals
f = other institutional providers
g = other non-institutional providers

1 = client characteristics
2 = type of eligibility
3 = service coverage limitations
4 = spend-down information
5 = third party payor information
6 = copayment requirements
7 = deductible information (Qualified Medicare Beneficiary)

* *= for some groups*
** *= system shows all recent periods of eligibility*
*** *= optional*
**** *= under development*

NR = No response
NA = Not applicable

Eligibility Verification Systems Under Development

Seven states reported their on-line eligibility system will be implemented in 1992, two states indicated the system will be up later in 1991 and two others specified 1993. In general, the survey responses indicated these new systems will be more comprehensive than systems that already exist.

Four states (AL, AR, MN, NC) indicated that the system will include point of sale devices, card swipes, telephone voice response, and provider PC systems. Of these four states, all but North Carolina intend to integrate on-line claims adjudication with the on-line eligibility system.

Six states intend to develop point of sale systems, and five of these will use card swipes. Six states will implement telephone voice response eligibility verification systems. Five states will move to provider PC based systems; only one of these states, Colorado, will not integrate the system with on-line claims adjudication nor telephone voice response. Four states intend to implement date specific eligibility with their new system.

Only one state among the eleven states responding to the question indicated that third party information will not be part of the client information given to providers.

Five states indicated that providers will bear no cost other than hardware for access to the new system. One state intends to provide the modem to providers to link their PCs to the eligibility system. Three states (two with voice response and PC based access, one with voice response only) intend to fund telecommunications costs.

All but one state indicated the system will be implemented to improve provider participation/relations. Six states indicated the purpose of the new system(s) is to provide cost savings and improve provider participation/relations. Only one state indicated the underlying purpose of the new system is solely to provide cost savings.

Five states (four of which anticipate very comprehensive systems) indicated they will receive enhanced federal matching payments. Arkansas and Illinois intend the eligibility verification system as part of a larger multi-program Electronic Benefit Transfer system. In Arkansas the program will be statewide, while in Illinois the program will be a pilot.

The following table summarizes state responses to questions concerning automated eligibility verification systems under development.

TABLE 3 - PLANNED ON-LINE ELIGIBILITY VERIFICATION SYSTEM (QUESTION 6)

State	Date	Avail. To Whom	POS	Card Swipe	Tel. Voice Response	Provider PC Base	On-line Claim Adjud.	Date Specific Eligib.	Client Info.	Provider Costs	XIX Asst.	Other Incentives	Purpose✚	Proof▲	Enhanced FFP	EBT
AL	'92	a, b, d, e, g	✓	✓	✓	✓	✓		2, 3, 5, 6		software, training, telecomm. costs		$ part.	NA	✓	
AZ	'92	Indian Health Service						✓	1-7, HMO Info.	hard-ware, line costs	software, training		$ part.	NA	✓	
AR	'92	a-e, g	✓	✓	✓	✓	✓	✓	1-5	trans. fee	hard-ware, soft-ware, training	quick payment, on-line claims submission	$ part.	NA	✓	✓ (state-wide)
CO	'93	a, c, g				✓		✓	3, 5	$49/month	modem, software, training	on-line claims submission	part.	NA		
GA	'91	a, b, d, e	✓		?				2, 3, 5	✓ ?	NR		part.	NA		
IL	NR	NR	✓	✓					NR	?	?	?	$ part.	NA	NR	✓ (pilot)
ME	'92	NA							3, 5		NR		$ part.	NA	NR	NR
MI	'92	a-e, ambulance			✓				1-3, 5, HMO, case mgt.		telecomm. costs		part.	NA		
MN	'93	a-e	✓	✓	✓	✓	✓	NR	3-5	hardware	software, training	NR	$ part.	NA	✓	NR
NC	'92	a-e	✓	✓	✓	✓		✓	2, 3		software, training, telecomm. costs		$	NA	✓	
PA	'91	a-g			?				2, 3, 5, 6	?	NR		part.	NA		
VA	'92	a-g			✓				3, 5, 6		NR		part.	NA		

✓ = yes
blank = no
NR = no response
NA = not applicable
? = not certain

a = pharmacists
b = individual medical providers
c = group health providers
d = nursing facilities
e = hospitals
f = other institutional providers
g = other non-institutional providers

1 = client characteristics
2 = type of eligibility
3 = service coverage limitations
4 = spend-down information
5 = third party payor information
6 = copayment requirements
7 = deductible information (Qualified Medicare Beneficiary)

✚ *Purpose of implementing the system: provider participation (part.) or cost savings ($).*

▲ *Whether the state can document either improved provider participation/relations (part.) or cost savings ($).*

On-Line, Real-Time Claims Adjudication

Only thirteen states responded affirmatively to the question about on-line, real-time claims adjudication. Only two states indicated that such a system was already implemented (Maine since 1985 and Utah since 1989). Of the two, only Utah indicated it has an operational on-line eligibility verification system which was also implemented in 1989. Six states (AR, FL, LA, MN, NY, OR) indicated that an on-line claims adjudication system was under development, generally scheduled for completion in 1992 or 1993. Louisiana was the only state in this group that does not appear to have an on-line eligibility verification system either under development or in operation. Five other states (IL, KY, NE, VA and WY) indicated that an on-line, real-time claims adjudication system was under consideration, and some of these states were able to provide some indication of the scope of the program under consideration. Of these states where an on-line adjudication system is under consideration, only Kentucky and Wyoming appear not to have an on-line eligibility verification system in operation or under development.

Only two states actually provided a definition of on-line, real-time claims adjudication. Both these states, Oregon and Utah, indicated their definition of on-line, real-time was actually an on-line, pre-adjudication system without real-time payment. This definition is consistent with the definition used by HCFA. Both Oregon and Utah included weekly batch-type payment of claims. Utah has an operable system while the Oregon system is still in development. Maine, the only responding state beside Utah with a functioning system, did not provide a definition. Louisiana, with a system under development, reported that a definition had not yet been decided upon.

APWA specifically did not define for states an on-line, real-time claims adjudication system because preliminary discussions with a variety of states indicated that there was no standard definition. On-line, real-time adjudication meant instant processing and adjudication to some, and simply on-line pre-adjudication or claims capture to others. The purpose in asking for a definition from states that answered affirmatively was to discern what states individually considered as on-line, real-time.

Ten of the thirteen states reported to which providers the system would be (or is) made available; all indicated the system would be, or is, made available to pharmacists. In addition, three states indicated the system would be, or is, available to individual providers. Three states reported the system would be, or is, available to hospitals, and one state indicated the system is available to nursing facilities.

By way of contrast, both Maine and Utah make their systems available to hospitals but only 1 percent of Medicaid hospitals are reported to use the Maine system while 90 percent of Utah's Medicaid enrolled hospitals use their system. In Maine, 85 percent of pharmacists use the on-line claims system while only 5 percent of Utah pharmacists utilize the system. Maine's system is used by pharmacists, nursing facilities and hospitals, and on-line submission represents 17 percent of total claims volume (16 percent, .5 percent, and .5 percent by provider type respectively). Utah's system is used by pharmacists, individual providers and hospitals. On-line claims submission represents 28 percent of total claims volume (13 percent, 10 percent and 5 percent of volume by the respective provider type). Maine reported receiving enhanced FFP for its system, but Utah reported it did not receive enhanced funding. Arkansas, Nebraska, and Oregon report either receiving or anticipating enhanced federal funding.

Five states were able to respond to the question about provider assistance and incentives to utilize the system. Among these states, two states contemplate providing hardware (Arkansas and New York). Only one state, New York, is considering funding provider telecommunications costs (New York also funds provider telecommunications costs for on-line eligibility verification implemented in 1986).

Improved provider participation/relations was the predominate reason reported by states for implementing or considering an on-line claims adjudication system. The two states that have implemented the system have not documented any cost-savings or improved provider participation/relations.

The following chart summarizes state responses.

TABLE 4 - ON-LINE CLAIMS ADJUDICATION (QUESTION #7)

State	Imple-mented	Date	Avail. To Whom	Percent Participa-tion	Percent Of Total Claims	Provider Costs	XIX Asst.	Other Incentives	Purpose✚	Proof▲	Enhanced FFP	EBT	Definition
AR		'92	a	NA	NA	$0.24/claim	1-3	better cash flow	$ part.	NA	✓	✓	
FL		'92	a	NA	NA	NR	NR	NR	NR	NA	NR	NR	NR
IL	*	NR	a	NR	NA	?	?	?	$ part.	NA	NR	✓	NR
KY	*	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
LA		'92-93	a	NA	NA	?	3	NR	NR	NA	?		?
ME	✓	'85	a b e	85% 1% 1%	16% .5% .5%	NR	NR		$ part.		✓		NR
MN		'93	a, b, e	NA	NA		2-3	faster payment	$ part.	NA			NR
NE	*	?	a	NA	NA	?	?	NR	faster payment	NA	✓	?	NR
NY		NR	a, b	NA	NA		1-4		part.	NA	NR		NR
OR		'92	a	NA	NA	?	?	faster payment	part.	NA	✓		pre-adjudication, weekly payment
UT	✓	'89	a b e	5% 5% 90%	13% 10% 5%		2-3		$ part.				pre-adjudication, weekly batch process
VA	*	NR	NR	NA	NA	NR	NR	NR	NR	NA	NR	NR	NR
WY	*	NR	NR	NA	NA	NR	NR	NR	NR	NA	NR	NR	NR

✓ = yes
blank = no
** = under consideration*
? = uncertain
NA = not applicable
NR = no response

a = pharmacists
b = individual medical providers
c = group health providers
d = nursing facilities
e = hospitals

1 = supply/fund hardware
2 = supply/fund software
3 = supply/fund training
4 = fund telecommunications

✚ *Purpose of implementing the system: provider participation (part.) or cost savings ($).*

▲ *Whether the state can document either improved provider participation/ relations (part.) or cost savings ($).*

Hierarchical Edits

Hierarchical editing within the MMIS generally is understood to mean that the claim is run through the system to ascertain all errors in the claim before it is placed in the pending file and/or returned to the provider for correction. This is in contrast to an edit system that rejects the claim from the system whenever there is an error so that the claim may be submitted and rejected several times with a new error discovered each time necessitating provider correction.

Thirty of the forty-four responding states reported that their MMIS uses hierarchical editing, although here again, it appears there is some variation in the definition of the term across states. Some states, such as Kansas, listed a number of claims errors that would cause a halt to the editing process. Other states specifically indicated that all validity edits would be run, but that a series of history edits (checking for duplicate payments, breach of benefit limits and the like) could not be run if key field elements were missing or incorrect. One state indicated that history edits could be run, even if client identifying information was missing or incorrect. Nine states listed errors in provider and/or client identification or eligibility as the only types of errors that would halt the claims edit process. Eight states cited date of service (D.O.S.) errors as either one error type among others or the only error type that triggers a payment processing halt. Two states identified third party liability (including Medicare) as one type of error, or indicator, that will halt payment processing. Two states, Maine and Utah, did not respond to the question on types of edits that cause the edit process to halt. What remains unclear from the survey is the extent to which provider and/or client identification/eligibility problems actually cause the claim to be rejected from the system as opposed to the extent to which claims with these types of errors are run through the full system to the extent possible (excluding for instance, all history edits).

Twenty-three of the reporting states indicated that hierarchical editing is applied to all claims, while seven states indicated that this edit method is applied to only some types of claims. In follow-up conversations with some states to clarify responses, one state suggested that while many states have hierarchical editing, many of the systems are programmed for multiple "fatal flaws" and cause a rejection from the claims processing system before the maximum amount of edits can be checked. The state suggested that a more reliable method of assessing the extent of hierarchical editing would be to look at state "pend" and "repend" rates. The pend rate would indicate the percentage of claims rejected needing resolution; the repend rate would indicate the number of resubmitted claims rejected again for errors. The repend rate would indicate the extent to which new errors were found on corrected claims once the claim proceeded to new edits. The assumption here is that the repend rate may provide a better indication of the scope of the hierarchical editing process; the higher the repend rate, the less extensive the first-round hierarchical editing may be.

Twenty-five of the responding states indicated the system was implemented to improve provider participation/provider relations. While many states felt participation/relations had improved, only one state, Wisconsin, indicated that it could document the improvement in provider relations. Fifteen respondents indicated that hierarchical edits were implemented to save money although no responding state could document such savings. Two states indicated that hierarchical edits were implemented to provide more timely payment, three states indicated they expected greater administrative efficiency/work flow as a result, and one state indicated that hierarchical editing allowed unified handling of problem claims. The following chart summarizes survey responses for those states indicating that hierarchical claims editing was implemented.

TABLE 5 - HIERARCHICAL EDITS (QUESTION 8)

State	Proc. Codes	Fatal Flaws	Implemented	Purpose[1]	Proof[2]
AL	some	missing/invalid D.O.S., missing/invalid proc. code, dup. payment, benefit limit	'85	part.	
AK	some	provider/client ID/elig.	NR	part.	
AZ	all	D.O.S. errors	'85	$ part., timely payment	NR
AR	some	provider/client ID/elig. among others	'85	part.	
CA	all	missing mandatory data elements	'79	part.	NR
CT	all	provider/client ID/elig.	'81	$ part.	
CA	some	client eligibility	'91	$ part.	
HI	all	provider/client ID/elig.	'82	part.	
IL	all	provider ID/elig.	'81	$ part.	
IA	all	provider/client ID/elig.	NR	part.	
KS	some	invalid D.O.S., invalid proc. code, invalid drug code, not run thru Medicare, no signature, no diagnosis, among others	'78	$ part.	NR
KY	all	D.O.S., provider/client ID/elig., invalid proc. code	'80	$ part.	
LA	some	provider/client ID/elig., D.O.S., others	NR	part.	
MI	all	NR	'85	expedite claims	
MD	all	provider/client ID/elig., D.O.S., among others	'80	$, part., better editing	
MI	all	all possible edits run before pending	'76	$ part.	
MS	all	provider/client ID/elig.	'85	part.	
MT	all	all possible edits run before pending	'85	part.	
NM	all	none	'91	part.	
NY	some	any data validity edits, history edits only done on clean claim	'77	$ part.	
OH	all	provider/client ID elig.	'86	NR	
OK	all	provider/client ID elig., proc. code, "etc."	'85	$	
SC	all	none	'85	$ part., efficiency	NR
SD	all	provider/client ID/elig., proc. code	'80	part., unified handling of problem claims	
TN	all	provider/client ID/elig., D.O.S., proc. code	'85	part.	
TX	all	provider/client ID/elig., TPL	'76	$ better work flow	
UT	all	NR	NR	part.	
VA	all	provider/client ID/elig.and D.O.S. prevent history edits	'78	$ part.	
WA	all	provider/client ID/elig., TPL, timely submission	'82	$	
WI	all	provider/client ID/elig.	'88	$ part., efficiency	

[1] *part. = provider participation/provider relations, $ = cost savings*

[2] *proof = ability to document improved cost savings or improved provider relations*

blank space = no

NR = no response

Miscellaneous Claims Issues

Forty-one out of the 44 responding states accept claims on tape. The three states that indicated they do not accept tape submissions are: Maine, Nevada (which does not have an MMIS) and Wyoming. Thirty-three of the responding states indicated that they have the capacity to accept claims submitted on computer diskettes. One state, Minnesota, indicated that it is in the process of developing this capacity. Minnesota also indicated that computer to computer claims submission is also under development; California clarified that it accepts claims via modem transmission. Otherwise twenty states indicated they have computer to computer claims submission capacity.

The survey asked states to estimate the proportion of claims that are submitted on paper (as opposed to submission through some type of electronic means, tape or diskette). The results showed that the level of automation in claims submission is not easily correlated to the size of the state Medicaid program. One state, New York, estimated the number of paper submissions at 20 percent of total claims volume. This was the lowest reported estimate. Alabama, Georgia, Maryland and Washington state were the group of states reporting the second lowest proportion of paper claims submission (between 21 and 30 percent). The group of states reporting the second highest volume of paper submissions (between 81 and 90 percent of total volume) were Alaska, Illinois, Maine and Montana. The Illinois Medicaid program uses electronic scanning of paper claims as a data entry device. This was begun in the early 1980's. Wyoming and Nevada (which does not have an MMIS) reported that 100 percent of claims are paper submissions. Five states did not answer the question on percentage of paper claims submission.

When queried about the provider types that submit predominantly on paper, eight states (KY, ME, NE, NM, OK, PA, TX, and VA) indicated that all provider types but pharmacy submit claims predominantly on paper. What is interesting here is the variety in the total reported estimated volume of paper claims as a percentage of all claims for these eight states where all claim types but pharmacy are submitted predominantly on paper. Maine, where pharmacists are the only reported provider group that submit predominantly via electronic means, reported a total paper volume of approximately 85 percent. Nebraska reported 70 percent and Virginia reported an estimated 65 percent of all claims are paper. In contrast, Pennsylvania where pharmacy was the only provider to predominantly submit through means other than paper, reported that only 45 percent of all claims were submitted on paper. Similarly, New Mexico reported 40 percent of total claims came through on paper. Kentucky and Oklahoma reported paper submissions around 50 percent.

Eight states reported that all provider types in the state submit claims predominantly on paper. In addition to those states reporting that all provider types submit predominantly using paper, only three states specifically cited pharmacy claims as predominantly submitted on paper (Utah, Louisiana and Minnesota). Similarly, except for those 13 states that indicated all providers (or all but pharmacists) submit mostly on paper, only six states specified hospitals as still using largely paper submissions (AL, AK, CT, KS, LA, NY). Only a few states indicated a level of automation among individual medical providers such that they were one group that did not submit mostly on paper (AR, CT, FL, HI, ID, KS). This could mean that the individual providers themselves are highly automated or that they use service bureaus which submit claims for them.

response to the question of whether the state uses the 1500 does not indicate the extent to which a state uses other claims forms. It should also be noted that a "yes" response to this question does not mean that the state has not modified the 1500 to comply with Medicaid reporting requirements that are not addressed by the standard HCFA 1500. While most states use a modified version of the 1500 for at least some claim types, other states did not use it for a variety of state-specific reasons, including the fact that the 1500 was not able to be electronically scanned at the time of the survey. Ten states indicated that they had revised the HCFA 1500 in 1989, 1990, or 1991. Two of these states, Wisconsin and Illinois indicated that EPSDT services were integrated into the 1500, while Utah indicated that EPSDT claims were coordinated with the HCFA 84. Arkansas indicated that its recent claim form revision was designed to reduce billing complexity for providers by eliminating certain fields from the claim form where the information can be otherwise cross-referenced from MMIS files. Arkansas did not provide a date for the format change.

The following table summarizes state agency responses to various questions on claims processing and formats.

TABLE 6 - MISCELLANEOUS CLAIMS ISSUES (QUESTIONS #9-14)

State	Tape To Tape	Floppy	CPU To CPU	Percent Paper	Paper Providers	HCFA 1500	Claim Revision	Year Of Change	Type Of Revision
AL	✓	✓	✓	30	b, d	✓		NA	NA
AK	✓	✓		85	a, b, d-g	*	✓	'89	accept ADA claim form, modified transpo. claim
AZ	✓			NR	a	✓	✓	'91	accept HCFA 1500, UB-82 and universal pharm. form
AR	✓	✓	✓	45	e, h-j	✓	✓	NR	eliminated claim fields that can be referenced from MMIS files
CA	✓	✓	modem	47	b, e			NA	NA
CO	✓		✓	60-75	b, e, f			NA	NA
CT	✓	✓	✓	49	d, e	✓		NA	NA
DE	✓	✓	✓	65-70	b	✓	✓	'90	accept HCFA 1500, UB-82, TAD
FL	✓	✓	✓	40	e	✓		NA	NA
GA	✓	✓	✓	30	b, e, g	✓		NA	NA
HI	✓	✓		55	e, h			NA	NA
ID	✓	✓	✓	55	e, h, personal care	✓		NA	NA
IL	✓			90	a		✓	'89	EPSDT integrated into standard claim
IN	✓			40	b			NA	NA
IA	✓	✓	✓	38	b, e, h	✓		NA	NA
KS	✓	✓	✓	47	d, h	✓	NR	NR	NR
KY	✓	✓	✓	50	a**	✓	✓	'90	
LA	✓	✓	NR	NR	b-d, f, i, k	✓		NA	NA
ME			NR	83	a**	✓		NA	NA
MD	✓			30	b, f, home health, personal care	✓		NA	NA
MI	✓			40	NR			NA	NA
MN	✓	1	1	NR	b, c	✓		NA	NA
MS	✓	✓	✓	55	a	✓		NA	NA
MT	✓	✓		86	a	✓		NA	NA
NE	✓	✓		70	a**	✓		NA	NA
NV				100	a	✓		NA	NA
NM	✓	✓	✓	40	a**	✓		NA	NA
NY	✓	✓		20	b, d			NA	NA
NC	✓	✓	✓	40	NR	✓		NA	NA
ND	✓	✓	✓	40	b, e, f			NA	NA
OH	✓			35	b			NA	NA
OK	✓	✓		52	a**	✓		NA	NA
OR	✓	✓		NR	b, e-g	✓		NA	NA
PA	✓	✓		45	a**			NA	NA
SC	✓	✓		50	b, e-g, i	✓		NA	NA
SD	✓	✓		80	a	✓		NA	NA
TN	✓	✓		66	b, e, g, h, j, home health, vision, waiver	✓		NA	NA
TX	✓	✓	✓	NR	a**	✓		NA	NA
UT	✓	✓	✓	80	b, c	✓	✓	'91	EPSDT coordinated with HCFA 84
VT	✓	✓	✓	50	b, f, g, k, lab, vision	✓	✓	'91	bed hold for long term care

(continued on next page)

(Table 6, continued)

State	Tape To Tape	Floppy	CPU To CPU	Percent Paper	Paper Providers	HCFA 1500	Claim Revision	Year Of Change	Type Of Revision
VA	✓	✓		65	a**			NA	NA
WA	✓	✓	✓	30	b, h, case mgt.	✓		NA	NA
WI	✓	✓	✓	39	b, f, h, j	✓	✓	'91	transpo. into HCFA 1500, EPSDT into HCFA 1500
WY				100	a	✓		NA	NA

a = all providers
b = individual providers
c = pharmacists
d = hospitals
e = nursing facilities
f = clinics
g = FQHCs
h = dental
i = transportation
j = EPSDT
k = DME
1 = under development
** = will process HCFA 1500 if provider uses it*
*** = except pharmacy*
✓ = yes
blank = no
NA = not applicable
NR = no response

Early and Periodic Screening, Diagnosis and Treatment

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) made some significant changes to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) component of Medicaid. The law enacted several policy changes. The first of these was that states were required to cover all medically necessary services for children regardless of whether the service is otherwise covered in the state plan. States must also cover the services in amount and duration as determined to be medically necessary; state plan limits on service amounts do not necessarily apply to each individual child. States are also now required to report an unduplicated count of children receiving the full complement of EPSDT screening services in a year. The law requires states to broaden the types of providers able to provide EPSDT services and must permit screens to be delivered in subcomponent parts by any variety of providers.

For many states, the OBRA 89 changes amounted to sweeping policy and program changes with significant fiscal impacts. Less well known were the changes required to the MMIS in order to comply with the changes. APWA used the survey to determine the type of changes required and the cost of systems modifications required.

Of the 44 states responding to the survey, only four states (IA, KY, MN, and WY) indicated that no systems modifications were required as a result of the OBRA 89 law. Tennessee and Utah did not respond to the questions on EPSDT. All other states indicated that systems modifications were required.

As discussed previously, Alaska and Indiana reported they had implemented an EPSDT subsystem while Arkansas and Montana indicated they are considering such a subsystem. In response to questions specifically about EPSDT, South Carolina indicated that it is developing an EPSDT subsystem. While OBRA 89 created the need for South Carolina to make some design changes, development of the subsystem began prior to OBRA 89.

Twenty-nine states indicated that new procedure codes had to be added so that payment could be made for services not covered under the state plan. Nineteen states responded that systems had to be modi-

fied to better track the periodicity of various screening services. Seventeen states reported that the system had to be modified for better correlation between screening and treatment services. Ten states reported that changes to the claim form were required in order to comply with OBRA 89, while no state indicated that it had gone to an EPSDT-only claim form as a result of OBRA 89.

Six states commented that OBRA 89 compliance required the addition of new provider types, and several states expressly mentioned development of new payment methodologies for previously uncovered services and modifications to issue newly required reports.

States were asked to indicate the state-only portion of the costs of systems modifications, and 28 states responded. Three states (Louisiana, New Mexico, and Wisconsin) indicated that modifications had been made at no cost. North Dakota reported that the systems modifications are estimated to generate an unspecified amount of savings because the state had previously issued EPSDT reports on a quarterly basis and the new law made reporting an annual requirement. Six states could not estimate the cost of EPSDT-related systems modifications. Eighteen of the 28 states were able to indicate the costs of the modifications which, as reported by the survey, totaled $1.68 million in state-only dollars. It is important to note several things about this $1.68 million figure. The first being that only two states, Alabama and Alaska, indicated that the reported state-only costs were actual, not estimates, while the other 16 states reporting costs used estimates. The second point is that states reported costs attributed to different fiscal years; depending on the state, costs were reported for 1991, 1992, or both (in a combined cost). Further, some states did not specify any fiscal year. Finally, ten of the states providing actual cost figures or estimates indicated that enhanced FFP was available for the expenditures, making total state/federal spending on EPSDT systems changes considerably higher than the $1.68 million reported by states.

The variety of cost and scope of changes required across states is probably due to several factors including the degree to which the state opted for the previous option of covering more services for EPSDT eligible children than it did for the rest of its Medicaid eligible population. The variety can probably also be explained by the extent to which a state separately tracked EPSDT services, again depending in large part on how extensive the state's overall Medicaid coverage was and the degree to which it had previously limited provision of specific services to specially qualified EPSDT providers.

Only 13 states indicated that all EPSDT-related systems modifications had been fully implemented. What the survey did not ascertain was the proportion of required changes that had already been implemented. The question was posed as a straight yes or no pertaining to all modifications so the responses could not convey gradations in implementation. A "no" response as to whether changes had been implemented does not mean a state has made no progress toward fully implementing the modifications. Similarly, a "no" response does not mean that a state is not paying for an expanded set of services. Procedure codes and new provider types could have been added, but the new reporting format may still be under development. A "no" response can also mean that some EPSDT claims are handled manually until the necessary changes are completed. In general, a "no" response is not indicative of whether children are receiving all medically necessary services nor is it indicative of whether or not providers are being paid for expanded services.

The following chart summarizes state responses to questions concerning modifications resulting from changes to the EPSDT program.

TABLE 7 - EPSDT (Question #15)

State	Changes Required	Type Of Changes	State-Only Cost	Cost Estimate	Changes Done	Enhanced FFP
AL	✓	a, b, g, h	$11,000-'90		✓	✓
AK	✓	a-c, f, g, new hardware	$50,000-'91			✓
AZ	✓	a-d, automated case mgt.	$5,000-'91	✓		✓
AR	✓	a	NR	NA	✓	✓
CA	✓	f, i	$2,000-'91	✓	✓	✓
CO	✓	a-c, dental periodicity	$65,000-'92	✓		✓
CT	✓	a-c, f	$24,000	✓		?
DE	✓	a-d, f	$30,000-'91	✓		✓
FL	✓	a-c, f	$500,100-'90/91	✓		✓
GA	✓	a, b, d, g	NR	NA	✓	✓
HI	✓	b-d	NR	NA		
ID	✓	b, c, i	NR	NA		
IL	✓	a	NR	NA		?
IN	✓	a	?	NA	NR	✓
IA						
KS	✓	a, h	NR	NA	✓	NR
KY						
LA	✓	a-c	0			
ME	✓	a, e	$20,000-'90	✓		
MD	✓	a-c	NR	NA	NR	NR
MI	✓	a, i	$10,000	✓	✓	
MN						
MS	✓	a, c, g, benefit bypass	$41,000-'90	✓	✓	
MT	✓	a, b, subsystem considered	$160,000-'91	✓		?
NE	✓	a-c	?	NA		
NV	✓	NR	?	NA		
NM	✓	a, d	0	NR		
NY	✓	c, i	NR	NA		
NC	✓	a-c	NR	NA		✓
ND	✓	i	savings	✓	✓	
OH	✓	c, i	$50,000-'91	✓		✓
OK	✓	a, c, d	$10,000-'91	✓	✓	✓
OR	✓	a-c	$3,000-'91	✓	✓	
PA	✓	a, g	?	NA	✓	
SC	*	new EPSDT subsystem	$500,000-'91/92	✓		✓
SD	✓	a, d	?	NA	✓	
TN	NR	NR	NR	NR	NR	NR
TX	✓	a, d, g	NR	NA		
UT	NR	NR	NR	NR	NR	NR
VT	✓	b, c, i	$3,570-'91	✓	NR	NR
VA	✓	a, d, on-line prior authorization	$200,000	✓		
WA	✓	a, c	?	NA		
WI	✓	a, d	0	NR	✓	
WY						

a = new procedure codes
b = correlate screens to treatment claims
c = tracking periodicity of screens
d = changes to claim form
e = create new EPSDT-only claim form
f = other
g = new provider types
h = new payment methodology for new services
i = new reports
✓ = yes
blank = no
** = planned prior to OBRA '89, but new law caused design changes*
? = unknown
NR = no response
NA = not applicable

Pharmacy

The survey queried states on both prospective and retrospective therapeutic drug utilization review (DUR) and asked background information on whether states used National Drug Codes (NDC) prior to April, 1991 when the OBRA 90 Pharmacy Reform provisions took effect. In order to implement pharmacy reform, states will have to use the 11-digit NDC eventually.

All but seven states use the NDC; those that did not use NDCs prior to April, 1991 were CA, IL, MI, MS, NE, TN and TX. In addition, six states (DE, IA, MN, OH, VA, WY) reported using a 9 or 10 digit NDC rather than the more standard 11 digit NDC employed by the majority of states.

No state reported that it had implemented an on-line prospective DUR system, although 15 states reported that such a system was either under consideration or under development. Five states reporting a system under development indicated that it would be implemented in 1992 or 1993. Of these five (IL, ME, NY, OR, TX), only New York was far enough along in the planning process to provide any general information, such as whether the costs would be eligible for enhanced federal reimbursement.

For retrospective therapeutic DUR, 19 states indicated that an automated system had either been implemented or was under consideration/development. The oldest reported retrospective system belongs to Florida, which implemented in 1982. Arkansas, Iowa, and Michigan implemented their systems in 1984.

In the majority of states with a retrospective therapeutic DUR system, or planning such a system, the system is, or will be, operated as a contract service, outside the MMIS. Four states indicated that the system is (or will be) part of the MMIS. With the exception of Florida, states reporting that retrospective DUR will operate as part of the MMIS all have newer DUR systems which had not necessarily come on-line at the time of the survey (Kansas, Louisiana, and Virginia). Florida's system was contracted out from 1982 until 1988 but has been run as part of the MMIS since 1988.

Five states reported that their system is designed by Health Information Designs (HID); three states reported using a design developed by The Computer Company (TCC). Three other states developed or are developing their own design.

Fourteen states cited cost savings as one of the reasons for implementing retrospective DUR. Seven of these states have had a system in operation for some time and could document cost-savings. Six states indicated that improved provider participation/provider relations was part of the justification for implementing the system. Of these six, only Arkansas, Ohio and Oregon have had an operational system for more than a year and only one, Oregon, can document improved provider relations/participation as a result. Fourteen states reported that improved client outcomes were the reason for implementing the system. Ten of these states have had their systems running for more than a year, but only five states (IA, KY, MD, OH, OR) indicated they could document improved client outcomes.

Five states reported that enhanced federal match is available for their retrospective system (AR, CO, FL, KY, LA). Pennsylvania, where the system is in the initial planning stage, was uncertain whether enhanced federal match would be available. Three states, Illinois, South Dakota and Wisconsin, provided no response while all others indicated enhanced match was not available.

The following tables highlight state responses to questions concerning prospective and retrospective DUR.

TABLE 8 - PHARMACY CLAIMS (QUESTION 16)

State	NDC*	NDC Digits
AL	✓	11
AK	✓	11
AZ	✓	11
AR	✓	11
CA		
CO	✓	11
CT	✓	11
DE	✓	10
FL	✓	11
GA	✓	11
HI	✓	11
ID	✓	11
IL		
IN	✓	11
IA	✓	10
KS	✓	11
KY	✓	11
LA	✓	11
ME	✓	11
MD	✓	11
MI		
MN	✓	9
MS		
MT	✓	11
NE		
NV	✓	11
NM	✓	11
NY	✓	11
NC	✓	11
ND	✓	11
OH	✓	10
OK	✓	11
OR	✓	11
PA	✓	11
SC	✓	11
SD	✓	11
TN		
TX		
UT	✓	11
VT	✓	11
VA	✓	10
WA	✓	11
WI	✓	11
WY	✓	9

** Use of National Drug Codes (NDC) prior to implementation of OBRA 90 Pharmacy Reform.*

TABLE 9 -PROSPECTIVE DRUG UTILIZATION REVIEW (QUESTION 17)

State	Pro-DUR	MMIS	Purpose	Enhanced FFP
AR	*			
DE	*			
GA	*			
ID	*			
IL	* (1993)			
KY	*			
ME	* (1993)			
NY	* (1992)	1	a-c	✓
NC	*			
OH	*			
OR	* (1992)			
TN	*			
TX	* (1992)			
VA	*			
WI	*			

** = under consideration/initial planning*

1 = part of electronic eligibility verification

a = cost savings
b = improved provider participation
c = improved client outcomes

TABLE 10 - RETROSPECTIVE DRUG UTILIZATION REVIEW (QUESTION 18)

State	Retro DUR	Date Implemented	MMIS	Design	Purpose	Savings Documented	Documented Provider Improv.	Documented Improved Outcomes	Enhanced FFP
AR	✓	1984	2	Health Information Designs (HID)	a-c	✓			✓
CA	✓*	1989	2	VA Computer Company	a, c				
CO	✓	1990	2	U of CO	a-c				✓
CT	✓**								
FL	✓	1982	1 (current) 2 ('82-'88)	HID	a, c	✓	NA		✓
IL	✓**	1992	NR	NR	a-c	NA	NA	NA	NR
IA	✓	1984	2	Iowa	a, c	✓	NA	✓	
KS	✓**	1992	1	EDS	a	NA	NA	NA	
KY	✓	1988	2	The Computer Company (TCC)	a, c	✓	NA	✓	✓
LA	✓	1991	1	TCC	a, c	NA	NA	NA	✓
MD	✓	1986	2	HID	c	NA	NA	✓	
MI	✓	1984	2	HID	a, c	✓	NA		
OH	✓	1985	2	HID	a- c	✓		✓	
OR	✓	1989	2	NR	a-c	✓	✓	✓	
PA	✓**	1992	NA	NA	NA	NA	NA	NA	?
SC	✓	1988	2	TCC	c	NA	NA	NA	
SD	✓**	1991	2	Medispan	a, c	NA	NA	NA	NR
VA	✓**	1992	1	Virginia	a, b, state mandate	NA	NA	NA	
WI	✓	1990	2	Wisconsin	NR	NR	NR	NR	NR

** = tri-county pilot project*
*** = under consideration/initial planning*

1 = part of MMIS
2 = contract service

a = cost savings
b = improved provider relations
c = improved client outcomes

NA = no answer
NR = no response
? = not certain

Other Systems Modifications

States were asked if other systems-related modifications have been or will be made to achieve cost savings or to improve provider relations. Seventeen states answered yes and provided descriptions of specific changes under development or already implemented.

Many states responded to this question by providing information on state plan coverage changes and reimbursement changes, such as increased payment for certain procedure codes. Since these are generally program policy changes, and are not systems driven, these changes are not discussed here.

In terms of actual system changes, Louisiana, Montana and New York are considering automated prior authorization systems for certain services. Several other states reported that they are looking to implement electronic claims submission for certain provider types or to expand current capabilities in this area. These states are Kentucky, Nebraska, South Dakota, and Texas.

Washington state reported that it is planning to expand its claims paid history file from 12 to 36 months to enhance third party recoveries and implement on-line claims adjustments. Both these modifications are estimated to produce savings for the Medicaid program.

Wisconsin reported that it is considering enlarging its provider relations staff in an effort to improve those relations. Mississippi reported that it is working to standardize more provider claim formats into the HCFA 1500 to simplify billing with the goal of improving provider relations.

California reported that it has implemented what appears to be a unique program to provide incentive for its fiscal agent to develop cost containment initiatives. The state shares with the fiscal agent a portion (ten percent) of any Medicaid savings generated by fiscal agent cost-containment initiatives. One such program initiated by the fiscal agent was the establishment of a unit to assist providers with small Medicaid caseloads in billing Medicaid. The unit saves money in that it better assures submission of correct claims so that less administrative time is spent reviewing claims for errors. The fiscal agent has also developed PC software for these types of providers to assist them in filling out claims forms. It would seem that this type of activity would also help improve relations between the Medi-Cal program and providers.

Summary

State agencies have made considerable progress in modifying their information and claims payment systems to better achieve cost savings and address the concerns of providers. Survey responses indicate that state agencies believe there is still more that can be done given the consideration states are giving to implementation of newer on-line eligibility verification systems, on-line claims adjudication or pre-adjudication, and the expressed interest in various types of drug utilization review.

In terms of innovation, the survey did not reveal any new major areas of systems innovation that fell outside the topics specifically address by the survey. The one program that was unique among responding states was the California program to provide incentives to the fiscal agent to develop effective cost containment programs. It also appears that automated prior authorization programs will become more widely implemented as states struggle to develop efficient ways to contain costs in an era when the program has greatly expanded. Several states also reported that they will be conducting a thorough review of their MMIS to see where improvements can be made and greater efficiencies can be achieved.

Appendix A

Systems Survey

AMERICAN PUBLIC WELFARE ASSOCIATION

James L. Solomon, Jr., President
A. Sidney Johnson III, Executive Director

MMIS SURVEY

This survey is designed to collect information on state systems changes undertaken in recent years which are targeted toward either cost-containment, improved provider participation or both, or which are necessary in order to comply with federal mandates. Please return to APWA by April 12, 1991 (return address on last page).

Background Information

1) State: _____

2) Name of Person Filling Out the Survey: _____
Title: _____
Phone: _____

3) Age of the MMIS: _____ years old

4) For each of your MMIS Subsystems, please specify the original designer (EDS, Unisys, The Computer Company, etc.) or the state from which the subsystem was transferred, or indicate if the subsystem was designed in-house:

Claims processing _____
SURS _____
MARS _____
Recipient _____
Provider _____
Reference File _____
TPL (if applicable) _____
Eligibility (if applicable) _____

5) Fiscal Agent, (if any) _____

On-Line, Real-Time Eligibility Verification

6) Has your state implemented, or is it planning to implement, on-line real-time eligibility verification? (not to be confused with IEVS federal requirements)
____ yes, implemented in FY____.
____ yes, to be fully operational in 19____.
____ no (skip to question #7.)

810 First Street, N.E., Suite 500, Washington, D.C. 20002-4205 (202) 682-0100 FAX: (202) 289-6555

a) To which provider types is the on-line real time eligibility verification made available (or will be)? Check all that apply and indicate the estimated proportion of providers within each provider type who use the on-line system, if the system is operational.

_____ pharmacists, _____% who use the system

_____ individual medical providers, _____% who use the system

_____ group health providers (HMO, HIO, PPO), _____% who use the system

_____ nursing facilities, _____% who use the system

_____ hospitals, _____% who use the system

_____ other institutional providers (please specify _____).

_____ other non-institutional providers (please specify _____).

b) Does the system use point of sale devices?
____ yes ____ no.

c) Does the system use card swipe?
____ yes ____ no.

d) Does the system use the telephone (for call-in voice response)?
____ yes ____ no.

e) Is the system integrated into provider PC system?
____ yes ____ no.

f) Is the system integrated with an on-line claims adjudication system?
____ yes ____ no.

g) Does the system operate on date-specific eligibility termination?
____ yes ____ no.

h) Does your system provide other client information
____ yes ____ no

(i) If you answered yes to 6h, what other types of client information is provided to health care providers through the on-line eligibility verification system? (check all that apply)

_____ client characteristics
_____ type of eligibility
_____ service coverage limitations
_____ spend-down information on medically needy
_____ third party payor information
_____ copayment requirements
_____ deductible information (QMBs)
_____other(pleasespecify_____)

(ii) Does the provider bear any cost for the information?
_____ yes _____ no. If yes, what is the fee? _____.

i) What types of assistance does the Medicaid program supply to providers utilizing the system? (check all that apply)

_____ supply/fund hardware (specify what hardware_____)
_____ supply/fund software
_____ supply/fund training

_____ fund telecommunication cost
_____ fund user fees (if applicable)

j) Does your state provide other incentives to providers to encourage use of this system? ____yes _____ no. If yes, please specify what incentives are provided by the state:
_____
_____
_____
_____

k) The primary purpose of implementing on-line, real-time eligibility verification system was/is to: (check all that apply)
_____ provide cost-savings (see i below)
_____ improve provider participation/provider relations (see ii below)
_____ other (please specify _____)

(i) If the primary purposes is to generate savings, do you believe the system has accomplished this? _____ yes _____ no _____ cannot determine. If yes, please specify savings in state-only dollars for the most recent state fiscal year available. $_____ FY 19_____. Is this an estimate? _____ yes _____ no.

(ii) If on-line eligibility was implemented to improve provider participation/relations do you believe it has improved? _____ yes _____ no _____ cannot determine. If yes, can your state document improvement in either relations or participation? _____ yes _____ no

l) Is the on-line real-time eligibility verification system funded as an MMIS enhancement subject to enhanced FFP? ____ yes ____ no.

m) Is the real-time eligibility verification system part of a multi-program Electronic Benefit Transfer (EBT) system? ____ yes ____ no. If yes, does the system operate statewide? ____ yes ____ no.

Electronic Claims Management

7) Does your state have on-line, real-time claims adjudication, or will it have such a system within the next 2-3 years?
_____ yes, implemented 19____ (year system went up)
_____ yes, under development. System anticipated to go on-line 19____
_____ no. (skip to question #8)

a) Please define your on-line, real-time claims adjudication system in terms of the length of time between claim submission and adjudication._____
_____
_____
_____

b) To which provider types is the on-line claims adjudication available (or will be)? Check all that apply and indicate the estimated proportion of providers within each type who use the on-line system if the system is operational as well as the estimated proportion of total claim volume.

_____ pharmacists, _____% who use the system, _____% of total claim volume

_____ individual medical providers, _____% who use the system, _____% of total claim volume

_____ group health providers,(HMO, HIO, PPO) _____% who use the system, _____% of total claim volume

_____ nursing facilities, _____% who use the system, _____% of total claim volume

_____ hospitals, _____% who use the system, _____% of total claim volume

_____ other institutional providers (please specify _____)

_____ other non-institutional providers (please specify _____)

(i) Does (or will) the provider bear any cost for the transaction? _____ yes _____ no. If yes, what is the fee? _____.

c) What assistance does the Medicaid program provide to providers participating in on-line claims adjudication? (check all that apply)

_____ supply/fund hardware
_____ supply/fund software
_____ supply/fund training
_____ fund telecommunication costs
_____ incentive payments

d) Does your state provide other incentives to providers to encourage use of this system? _____ yes _____ no. If yes, please specify what incentives are provided by the state:

_____

_____

_____

_____

e) The primary purpose(s) of implementing on-line claims adjudication system was/is to: (check all that apply):

_____ provide cost savings (see i below)
_____ improved provider participation/provider relations (see ii below)
_____ other (please specify _____)

(i) If the primary purpose is to generate savings, do you believe the system has accomplished this? _____ yes, _____ no, _____ cannot determine. If yes, please specify savings in state only dollars for the most recent state fiscal year available. $_____ SFY 19_____. Is this an estimate? _____ yes _____ no.

(ii) If on-line claims adjudication was implemented to improve provider participation/relations, do you believe it has improved? _____ yes, _____ no, _____ cannot determine. If yes, can the state document improved participation/relations? _____ yes _____ no.

f) Is the on-line claims adjudication system funded as an MMIS enhancement, subject to enhanced FFP? ____ yes ____ no

g) Is the on-line claims adjudication system part of a multi-program Electronic Benefit Transfer (EBT) System? ____ yes ____ no. If yes, does the system operate statewide? ____ yes ____ no.

Hierarchical Edits

8) Have you implemented or will you implement a system of hierarchical claims editing so that a claim will go through all, or almost all, edits before the unpaid claim is sent back to the provider for correction? _____ yes all procedure codes, _____ yes for some procedure codes, _____ no. (If no, skip to question #9)

a) If you use hierarchical claims editing, are there certain errors that will trigger rejection from the system before the claim has been run completely through the system? ____ yes ____ no. If you answered yes, please specify which errors on the claim form would trigger a halt to the editingprocess._____

_____

_____

_____

b) When was hierarchical editing implemented, or if not yet operational, when will it become so? 19___ (please specify).

c) The primary objective of your hierarchical edit system is: (check all that apply)
_____ cost savings (see i below)
_____ improved provider participation/relations? (see ii below)
_____ other (please specify)_____

(i) If the primary purpose is to generate savings, do you believe the system has/will accomplish this? _____ yes, _____ no, _____ cannot determine. If yes, please specify savings in state-only dollars for the most recent state fiscal year available. $_____ SFY 19_____. Is this an estimate? _____ yes _____ no.

(ii) Do you feel hierarchical editing has improved provider participation/relations? _____ yes, _____ no, _____ cannot determine. If yes, can the state document improved provider relations? _____ yes _____ no.

Miscellaneous Claims Issues

9) Does your state accept tape to tape claims submission? _____ yes _____ no

10) Does your system accept claims on floppy disks? _____ yes _____ no.

11) Does your state accept computer to computer claims submission (CPU to CPU)?
_____ yes _____ no

12) What estimated percentage of claims are submitted on paper? _____%.

a) What provider types submit claims predominantly on paper? (check all that apply).
_____ all providers
_____ individual providers
_____ pharmacists
_____ hospitals

_____ nursing facilities
_____ clinics
_____ FQHCs
_____ others (please specify_____)

13) Has your state recently revised the claim form/format to address provider concerns about billing complexity? ____ yes ____ no.

a) If yes, use the space below to briefly explain the changes.

_____

_____

_____

_____

b) The most recent change to claim form/format to simplify billing was made in 19 _____.

14) Does your state use the standard HCFA 1500 claim form? _____ yes _____ no.

EPSDT

15) Has the EPSDT mandate of OBRA '89 resulted in any changes to your system to comply with the service and/or participation requirements? ____ yes ____ no.
Please specify what changes have been, or will be, made to the MMIS. (check all that apply).
_____ addition of new procedure codes
_____ greater correlation between screening codes and subsequent treatment claims
_____ greater system ability to track periodicity of screens
_____ changes to the existing claim form
_____ creation of new EPSDT-only claim form
_____ other (please specify _____)

a) What will be the state-only cost of systems modifications required by the new EPSDT law, $_____ in SFY 19_____. Is this an estimate? _____ yes _____ no

b) Are all systems changes required by the new EPSDT law implemented yet?
____ yes ____ no.

c) Are EPSDT-required systems changes funded with enhanced FFP? _____ yes _____ no.

Pharmacy Claims

16) Does your state use National Drug Codes (NDC) **(prior to implementing the new pharmacy law of OBRA 90)**? _____ yes _____ no.

If yes, does your state use: _____ 9 digit NDC, _____ 10 digit NDC, _____ 11 digit NDC.

17) Does your state utilize (or plan to implement) an on-line, real time prospective drug utilization review (DUR) system based on a statewide data base (not to be confused with prior authorization):
_____ yes, implemented FY 19_____.
_____ yes, to be fully operational in 19_____.

_____ no (skip to question #18).

a) If yes, please specify whether:
_____ the system is part of the MMIS
_____ the system is a contract service apart from the MMIS
_____ other (please explain_____
_____
_____
_____)

b) The primary objective of automated prospective DUR is (check all that apply)
_____ cost savings (see i below)
_____ improved provider participation/provider relations (see ii below)
_____ improved client outcomes (see iii below)
_____ other (please specify _____)

(i) If your state implemented on-line prospective DUR for cost savings, do you believe savings have been achieved? _____ yes, _____ no, _____ cannot determine. If yes, please specify state-only savings for the most recent state fiscal year available. $_____ in SFY 19_____. Is this an estimate? _____ yes _____ no

If your state is implementing prospective DUR for cost savings, please provide estimated state-only savings for the first full year of operation. $_____.

(ii) If your state implemented prospective DUR system to improve provider participation/relations, do you feel such participation/relations have improved? _____ yes, _____ no, _____ cannot determine, _____ relations/participation has declined. If yes, can your state document improvement? _____ yes _____ no

(iii) If prospective DUR was implemented to improve client outcomes, do you believe the system has done so? _____ yes, _____ no, _____ cannot determine. If yes, can the state document such improvement? _____ yes _____ no.

c) When did (will) your system become operational? 19_____.

d) Is the system funded through enhanced FFP? _____ yes _____ no.

18) Does your state utilize an automated retrospective therapeutic drug utilization review (DUR) system (not to be confused with SURS)?
_____ yes, implemented 19_____.
_____ yes, to be fully operational in 19_____.
_____ no (skip to question #19)

a) If yes, please specify whether:
_____ the system is part of the MMIS
_____ the system is a contract service apart from the MMIS
_____ other (please explain: _____
_____)

b) The system design was created by:
_____ the state
_____ other (please specify the model such as the Iowa system, TCC, etc.)

_____

_____

_____

c) The primary objective of the retrospective DUR is: (check all that apply)
_____ cost savings (see i below)
_____ improved provider participation/provider relations (see ii below)
_____ improved client outcomes (see iii below)
_____ other (please specify _____)

(i) If your state implemented automated retrospective DUR for cost savings, do you believe cost savings have been achieved? _____ yes, _____ no, _____ cannot determine. If yes, please specify state-only savings for the most recent fiscal year available. $_____, SFY 19_____. Is this an estimate? _____ yes _____ no.

If your state is implementing automated retrospective DUR for cost savings, please provide estimated state-only savings for the first full year of operation. $_____.

(ii) If your state implemented automated retrospective DUR to improve provider participation/provider relations, do you feel such participation/relations have improved? _____ yes, _____ no, _____ cannot determine, _____ relations/ participation have deteriorated. If yes, can improvement be documented?
_____ yes _____ no.

(iii) If automated retrospective DUR was implemented to improve client outcomes, do you believe it has done so? _____ yes, _____ no, _____ cannot determine. If yes, can the state document improvement? _____ yes _____ no.

d) When did (will) the system become operational? 19_____.

e) Is the system funded through enhanced FFP? _____ yes _____ no.

19) Are there other systems changes your state has made, or intends to make, to achieve either cost-containment or improve provider participation/provider relations?
____ yes ____ no.

a) If yes, please use the space provided below to briefly describe the innovations and the goal of each innovation. If the goal is cost savings, please specify savings either estimated or known. Please attach another page if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your assistance.

Please return completed surveys by **April 12, 1991** to:

Jane Horvath, Director
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